Return completed form to:
Lodi Primary School
1307 Sauk Street, Lodi, WI 53555
Phone: (608)592-3855
Fax: 608592-1015

Lodi School District
Health Care Provider Report of Student's 4 Year Old Kindergarten Physical Examination

Student: _____ M F Birthdate: _____ School: _____

Parent: _____ Phone: _____

Complete address: _____

I give permission for the clinic to release this information to the Lodi School District.

_____ _____
Parent Signature **Date**

Immunizations

Please complete the attached, Student Immunization Record including items in Step 5 at the bottom of the first page. A printout of your child's immunization dates may be attached. If you are completing a waiver for any of the requirements, please follow the instructions on the Student Immunization Record thoroughly.

Students with immunization waivers in place for any reason will receive notification of vaccine preventable disease cases in the school setting and guidance on what to do to keep self and others safe. This is done in conjunction with the local health department and may include directions on keeping the un- or under-immunized child at home during communicability.

Medications

**For your student to be given medication at school, a medication form for either prescription medication or OTC medication must be filled out and returned to school. Medication must come in the original pharmacy package with matching instructions to the form, or in the original packaging from the store. The Medication Request/Consent Form is available online at https://www.lodi.k12.wi.us/our-families/health-services or in the school office. Medication needs to be brought to school by a parent to the office. Do not send medications to school with students.

Students with Health Concerns

If your child has a health concern, please discuss their needs with the school nurse. The school nurse may assist with developing an appropriate health plan or obtaining medical action plans from medical providers. Building level staff is then trained on meeting student needs. Contact Janelle Sivam, School Nurse at (608)573-1851, sivamja@lodischoolswi.org.

--OVER—

Student Name: _____
DOB: _____

This portion is completed by the health care provider

Ht _____ (inches)	General appearance
	_____
Wt _____ (pounds)	_____
Blood Pressure _____	Skin _____ Eyes _____ Ears _____
Lead screening results _____	Nose _____ Mouth _____
_____	Throat _____ Teeth _____
_____	Respiratory _____
Vision screening, if eye exam not scheduled	Cardiovascular _____
Right _____ Left _____	Gastrointestinal _____
Glasses-At all times/Reading/Distance only	Genitourinary _____
Hearing screening	Muscular/Skeletal _____
Right _____ Left _____	Neurological _____

Comments: _____

_____

Does child see a dentist? **yes** **no** Does your child have dental health concerns? **yes** **no**

Does this child have a health concern which may require an EMERGENCY ACTION PLAN while s/he is at school? Attach a plan printout please. (e.g. seizure disorder, diabetes Type 1 or 2, cardiac issue , asthma, bleeding issue, insect sting allergy, severe food allergy) **€ yes** **€ no**

List any allergies and specific reactions.

Are any allergies LIFE-THREATENING? **€ yes** **€ no**
If yes, please describe.

Does the student need an epinephrine auto injector?** **€ yes** **€ no**

Is this student on daily medication? **€ yes** **€ no**
If yes, please list medication, dosage and frequency.**

Are there any physical activity restrictions or physical education in school? **€ yes** **€ no**
If yes, please describe nature, duration and any special equipment used.

Does the student need special nutritional consideration? **€ yes** **€ no**
If yes, please describe.

Are there any other significant findings on exam, family or health history that may impact this child's health or learning at school? **€ yes** **€ no**

****A Medication Request/Consent Form must be completed in order for school staff to administer medication at school.**

Signature/title of health examiner: _____ Date: _____

Printed or typed name of examiner: _____

Address of examiner: _____ Phone number: _____